



Update on strategies for Complex Needs Patients

October 27, 2016

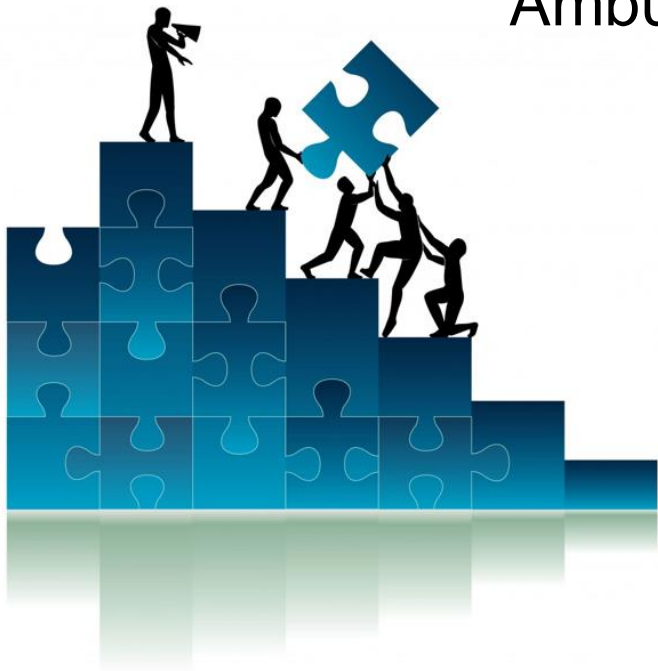


Infrastructure for Population Health

Patient Centered Medical Homes
Ambulatory Case Management

Hospital-based Transition Team
Transition Care Clinics

Epic Population Health Functionality



Addressing needs for Complex Inpatients at West Virginia University Hospitals

- 11 Internal Medicine Inpatient Services
- 725 discharges per month
- 30%+ Medicaid or dual eligible
- Daily 10 patients or more discharged with above average risk for readmission
- High percentage “unassigned” or “medically homeless”
- Current Care Management staff cannot meet all complex needs

→ Hospital Transition Team developed for high risk patients

Transition Team Pilot

- Goal to reduce readmissions and improve transition care
- Medicine 1 service initially → expanding to Med 1 through 5
- Started in Fall 2015, expanded staff in 2016
- Admissions screened for risk factors (LACE, social determinants)

Admission Review
Risk Alerts

Chart Review and
Bedside Interviews

Coordinate care
Arrange follow up
Connect to Community
Resources

Phone Follow Up
Track care





Andrea Bailey APRN

Team lead
Collaborates with physicians and care management
Transition Clinic implementation.

“each team member plays a unique role, using an array of assessment skills to intervene with those at highest risk”

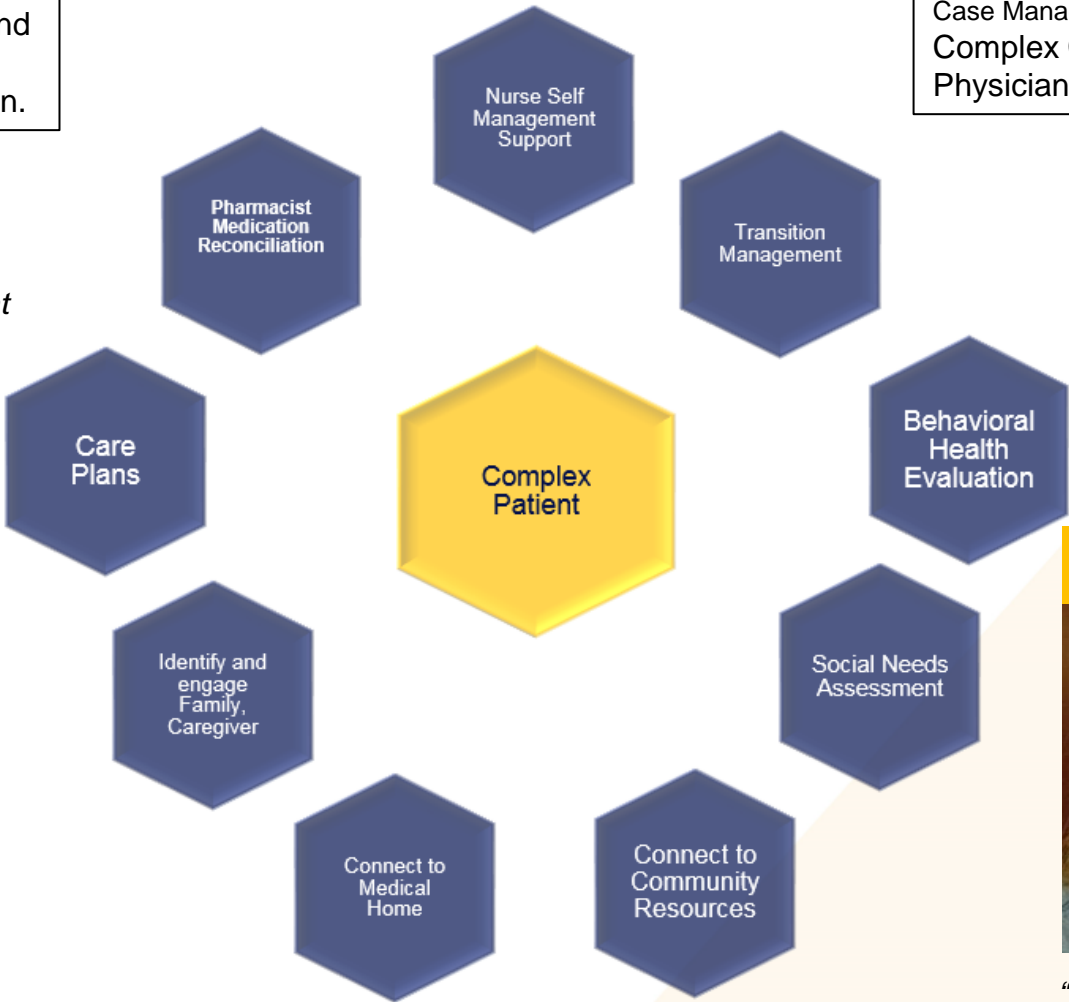
Dawn Martin RN



Identifies at risk patients
Bedside Transition care
Connects to PCP
Coordinates follow up

“thrilled to be a member of the transitions team”

Transition Team



Karen Clark, MD



Case Management Medical Director
Complex Care Plans
Physician Leadership

Meghan Kline LSW



Targets social barriers
Behavioral conditions,
Community connections

“I have the privilege of helping patients face some of the most adverse times in their lives”

RN Case Manager

Second RN supports transition care,
post-hospital follow-up calls and
care coordination (new hire)

Medicine Transition Clinic

- Post-hospital follow up with Transition Clinic if not well established with PCP
- Pilot with two Med services
- 2 afternoons per week will scale to 5 full days per week
- Will bridge patients to more permanent medical home
- Staffing
 - Advance Practice Professionals (continuity) and Medicine physician/residents
 - Inpatient transition team provide continuity
 - Exploring expanded inter-professional resourcing
 - pharmacist, social work, behavioral health
 - Ambulatory Care coordinators



Behavioral Health Conditions are Key Drivers

	Medical Conditions	Addiction or Suspected Addiction	Behavioral Health	Social Factors	Current Care Coordination
Patient A	CHEST PAIN		DEPRESSION PTSD		ACT team, PCP
Patient B	HEART DISEASE COPD	OPIOID SEEKING			PCP
Patient C			SOMATIZATION, SCHIZOAFFECTIVE	Unsafe home situation	ACT team, PCP, CARE PLAN
Patient D	ASTHMA CANCER		SCHIZOAFFECTIVE SUICIDALITY		ACT team, PCP
Patient E	DIABETES HEART DISEASE CHRONIC PAIN	OPIOID SEEKING ALCOHOL ABUSE	BIPOLAR AFFECTIVE DISORDER		ACT team, PCP
Patient F	DIABETES HEP C HEART DISEASE	ALCOHOL ABUSE in remission	DEPRESSION SUICIDALITY		PCP
Patient G	Liver Cirrhosis and Liver transplant				PCP
Patient H	CHRONIC PAIN CANCER	OPIOID BENZO ALCOHOL		HOMELESS	no PCP, CARE PLAN

Acute care plan

- Alerts at Point-of-care
- Consensus acute care treatment plan created with patient's care team for:
 - Patients requiring customized treatment protocols
 - Patients with drug seeking behavior
 - Opioid dependence and pain presentations
 - Patients with risk for cumulative radiation exposure
- Provides succinct evidence-based guidance for ED and hospitalist teams
- Shared with the patient

Care Plan while in the ED:

1. Prompt screening medical examination; follow care plan if *{specify presentation}*
2. Protocol orders for imaging should not be used due to concern for cumulative radiation exposure.
3. Order UDS upon presentation (prior to medication administration)
4. IV pain medications will be avoided unless patient is ordered NPO
5. Consider observation status if admission for subjective complaints related to *{specify presentation}*

The Primary Care/Hospitalist will:

1. Present to ED to evaluate the patient
2. Pain resource team should be consulted for all admissions within 24 hours.
3. Avoid IV pain medications and avoid writing narcotic prescriptions at the time of hospital discharge except as needed to accomplish a taper. Suboxone may be beneficial for long term management of pain and opioid dependence in this patient. Pain resource team should be consulted before initiating.
4. Follow up on results for UDS.
5. Aid the patient to find a primary care provider.
6. Respond promptly to calls from the patient.

NOTE: The care plan was developed to improve adherence to treatment and promote better outcomes of care. All patients presenting to the ED receive a screening medical examination and have their emergency medical condition, if present stabilized. All care is rendered with respect for patient privacy and dignity. No part of the care plan is intended to interfere with the clinical decision-making of the treating physician.

Patient C

Care Plan process began in 2015 with PCP, ACT, Psychiatrist, ED
Treatment team coordinated approach
Goal to decrease use of radiographs

- Somatization Disorder
- Poor family situation
- Poor social support
- Borderline Intellectual Functioning
- Connected to PCP and ACT program
- ED Presentations:
 - Reports of falls, injuries, MVA, chest pain
 - Suicidal or Homicidal Ideations
 - Violent “acting out”
 - Numerous normal radiographs
- Primarily Psychiatric Hospitalizations

Reduced Utilization

1 year Utilization	Jun-15	16-Jun
Ambulance	55	25
ED	56	36
Hospital	8	14

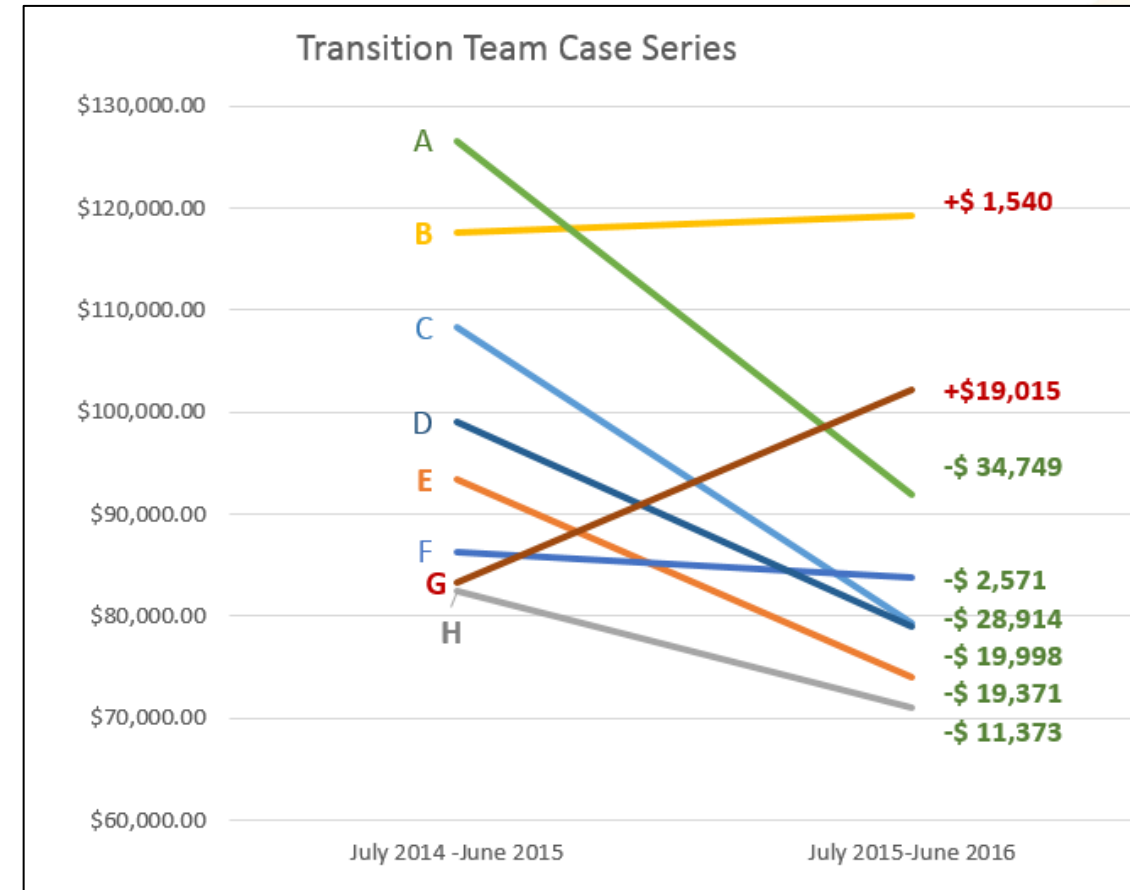
ED Care Plan

1. Medical screening
2. Call ACT crisis line –staff to speak to patient
3. Consider notifying security
4. Female staff should be assigned whenever possible
5. Staff physicians rather than residents when possible
6. Careful consideration for imaging due to concern for cumulative radiation
7. Observation status recommended for admissions related to subjective complaints of chest pain
8. Psychiatric admission only after evaluation by attending psychiatrist

Total cost reduced \$ 28K

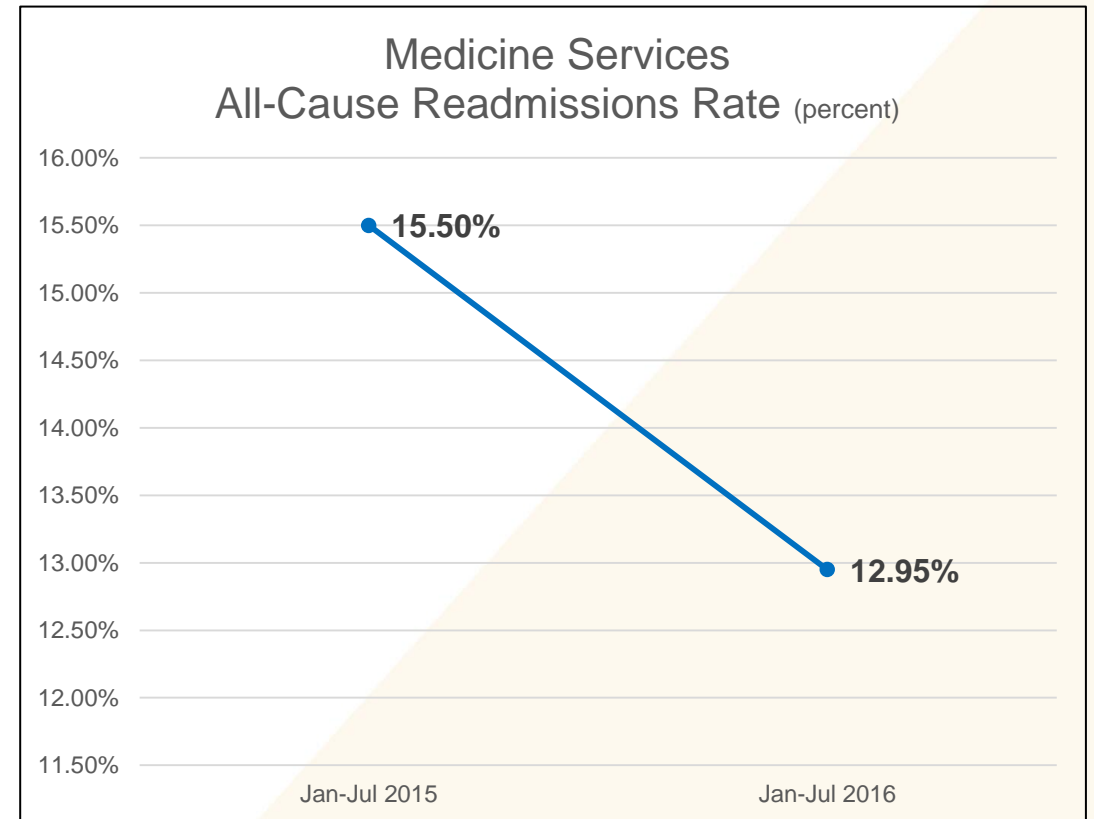
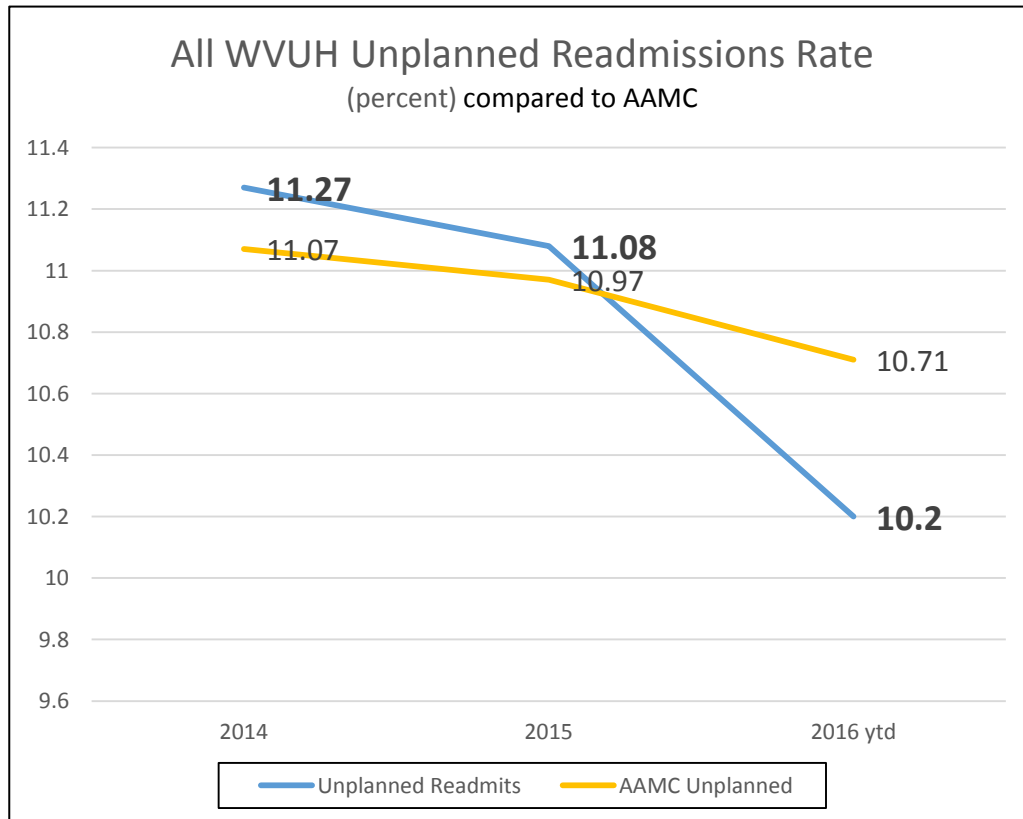
Cost Trending

Total Annual Cost	July 2014 -June 2015	July 2015-June 2016	Cost Difference
PATIENT A	\$126,649.37	\$91,900.50	-\$34,749
PATIENT B	\$117,661.55	\$119,201.74	+\$1,540
PATIENT C	\$108,291.88	\$79,377.83	-\$28,914
PATIENT D	\$99,016.47	\$79,018.10	-\$19,998
PATIENT E	\$93,444.71	\$74,073.74	-\$19,371
PATIENT F	\$86,371.82	\$83,800.42	-\$2,571
PATIENT G	\$83,243.95	\$102,258.74	+\$19,015
PATIENT H	\$82,489.88	\$71,116.55	-\$11,373
			-\$96,422



Readmissions

inpatient (observation stays not included)



16.5% year over year reduction

Questions

- Medical homelessness
 - how to connect to a medical home??
- Substance abuse treatment
 - how to effectively triage?
 - What referral process?
 - Strategies for precontemplative?
- Resourcing for Care Coordination
 - Alternate Payment Models?
 - Transitional Care Management
 - Multipayer approach?
- Data sharing
 - How to automate?
 - What role for HIE?

Next Steps

- Scale up Transition Clinic
- Optimize process for Acute Care plans
- Behavioral Case Manager / Integration
- Review/update ED protocols for pain treatment
- Epic Healthy Planet tools
 - Predictive analytics
 - Point of care flags
 - Longitudinal Plan of Care
 - Social Determinants as discrete data

